

# STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

IC File # \_\_\_\_\_

Emp. Code # \_\_\_\_\_

Carrier Code # \_\_\_\_\_

Carrier File # \_\_\_\_\_

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act Employer FEIN \_\_\_\_\_

Employee's Name \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

( ) - ( ) -

Home Telephone Work Telephone

/ / / /

Social Security Number Sex Date of Birth

Date of Injury: / /

Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) - ( ) -

Carrier's Telephone Number Fax Number

Year: 200	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned
Jan.																																
Feb.																																
Mar.																																
Apr.																																
May																																
June																																
July																																
Aug.																																
Sept.																																
Oct.																																
Nov.																																
Dec.																																
Total																																

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? \_\_\_\_\_

If so, state weekly value thereof: \$ \_\_\_\_\_.

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

The undersigned employer of \_\_\_\_\_  
(Name of Employee)  
who alleges an injury on the \_\_\_\_\_ of \_\_\_\_\_, **200**  
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

By \_\_\_\_\_  
Employer  
Authorized Signature  
**/ /200**  
Date Signed

**To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.**

## INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

### SELF-INSURED EMPLOYER OR CARRIER MAIL TO: